Joe Rogan and Dr. Robert Malone, MD interview TRANSCRIBED (Joe Rogan Experience #1757)

Preface

Joe Rogan has his podcast exclusively on Spotify. It's 3 hours long. Some people don't have Spotify. Some people don't have 3 hours to listen to a guy talk very slowly. I took the time to type out the main points brought forth by Dr. Malone. The podcast is about 95% Dr. Malone talking, with the remainder as Joe. If you do not have Spotify, you can listen to it from this link here which is unlikely to be taken down.

Formatting:

1. When Dr. Malone speaks, I use the ">" quote function.
2. When Joe speaks, I put "Joe:" in front of the statement.
3. When I paraphrase a verbose point, I have it as a bullet. Interviews are often a bit rambly, especially when they're three hours long. When people try to get a point out, it tends to get dragged out as they try to on-the-fly figure out a way to describe it the best. I did *my* best to boil it down to what they were actually trying to say, using their own vocabulary. I understand this may upset people, but that's why I link to the original podcast above.
4. When I skip through or alter a quote for sake of simplicity, it is in brackets "[]".
5. I sometimes add clarifying statements in parentheses.

Transcriptionst's Note:

This is simply a volunteer effort to let this information be more easily spread. At some point I'll spit this whole episode through an automated AI transcriber, but I don't exactly know how to do that. There is a lot of stuttering, stammering, and on-the-fly rewording that I've left out, so I do not consider my omission of those instances as being unfaithful to the dialogue. I've also left out a lot of side-talk like "wow" and "oh my gosh", ya know the thing that Joe Rogan does a lot. I deliver information in chronological order as it is presented in the interview. At the time of this post, this will not be the final iteration and is subject to change and improvement. If you have an issue with the way I've transcribed something, please include what you would like me to edit and I will. If you have the studies that Dr. Malone references, please consider including it in a comment so that I can paste it where appropriate. I greatly recommend that you listen to the full podcast if possible. Feel free to cross-post this to your underground communities.

Dr. Malone's testimony about himself:

- Robert was present in the main labs that were responding to the very first HIV outbreak
- Developed a series of technologies about how to manufacture mRNAs, structure it and eventually put it into cells (eventually leading to the development of these COVID vaccines)
- Robert has been involved in every major outbreak since AIDS
- Has won billions of dollars in federal grants
- Brought in by NIH to serve as the "study section chair"

- Countless hours working for the CDC, has many friends in the CDC
- A " deep insider" in terms of government
- Has known Tony Fauci personally, has worked with him his entire career
- Does not receive any money from the popularity of his tech
- De-platformed from LinkedIn for noting a conflict of interest regarding officials in Pfizer
- was reinstated after LinkedIn admitted they didn't have the "talent to fact check him"
- Was de-platformed again after a Microsoft fact checker concluded that Robert was an "anti-vaxxer" and was therefore deserving of a ban
- Banned from twitter but unsure what specific tweet kicked him off (Twitter never tells)
- Suspects that it was one of two tweets that had to do with informing Pfizer vaccine potential defects, as well as how large information-direction organizations are dealing with COVID media

Main Interview:

I've tried to make sure people have access to the information about those risks and potential benefits, the true unfiltered academic papers and raw data, etc...

The policy being implemented is one in which no discussion of the risks are allowed, because by definition they will allow vaccine hesitance. Because of this, Informed Consent is not happening, and it is in fact being blocked.

There's a CIA agent I've co-published with in the past named Michael Calahan. He was in Wuhan in the 4th quarter of 2019. He called me from Wuhan on January 4th. At this time I was managing a team that was focusing on drug discovery for organo-phosphate poisoning, ergo nerve agents, for DTRA (Defense Threat Reduction Agency), involving high performing computing and bio-robot screening. He told me, "Robert, you've gotta get your team spun up because we've got a problem with this new virus." I've worked with him through prior outbreaks. So it was then when I turned my attention to this. I started modelling a key protein of this virus, a protease inhibitor, when the sequence was released on January 11th as the "Wuhan Seafood Market Virus." I've been going nonstop on this ever since (to that point, with drug repurposing). I'm the one that originally discovered famotidine as an agent because I was self-treating myself after I got infected with agents that we identified through our computer modelling.

I was up up up on all the latest information from China and everywhere else. I knew all about this virus. I watched all the videos of people dropping in the street. My lungs were burning until I took famotidine, otherwise known as Pepcid.

- Today (Dec 31) the first patient is enrolled in clinical trials for the combination of famotidine and celecoxib for treating SARS/COVI-2. It is based on Malone's discoveries.
- We had data to show that Ivermectin improves the combination [famotidine and celecoxib], but the FDA created enormous roadblocks to us doing an Ivermectin arm that we had to drop it. The FDA created so much grief that the DOD decided the "juice wasn't worth the squeeze".
- It's not just Ivermectin [that they're putting a stop to], it's also hydroxychloroquine.

There is good modelling studies that probably half a million excess deaths have happened in the United States through the intentional blockade of early treatment by the US government. Half a million. That is a well-documented number. And that's about the combination of hydroxychloroquine and ivermectin.

If you ask me why this is happening, you're asking me to get into somebody's head. What I can say as a scientist is what I can observe: the behaviors, the actions, the correspondence.

- Zev Zelenko [...] clearly documents the conspiracy between Janet Woodcock and Rick Bright to make it so that physicians could not administer hydroxychloroquine outside of the hospital.
- Rick Bright was head of the BARDA (Biomedical Advance Research and Development Authority) which is the group that, for instance, funded the J&J vaccine and Operation Warp Speed, etc...
- BARDA is the "big ticket funder" of bio defense products
- Janet Woodcock was head of Operation Warp Speed for drugs, and until very recently head of the FDA. She is known as the person that kind of gets the credit for the Opioid Crisis for her role at the FDA.

Rick Bright in videotaped testimony has explicitly spoken about how they conspired to cook up a strategy using Emergency Use Authorization to make it so that hydroxychloroquine could only be administered in the hospital which is far too late for when hydroxychloroquine should be used.

Joe: Why do they do that?

That is what is the unknown. And there are so many whys and hows behind this. There's a stack of stuff that doesn't make sense that's about this high [hand gesture]. I can't get into Rick's head, though I know Rick quite well. He's currently working for the Rockefeller. He did a whistleblower case and then he left the government. All I know is that they did this, and that Rick admits on videotape that he did it. He claims that the reason was is that he believed there was no evidence of hydroxychloroquine being useful for this virus. Now that's false. Hydroxychloroquine was known to be effective against SARS-1.

Hydroxy is one of the few molecules that have antiviral activity that is safe in pregnancy.

The other part of Rick's story that kinda doesn't make sense, that there was no data of efficacy, is that I was the guy that first acquired, because I had Chinese connections, the Chinese protocol for treating this virus. I got it in late February, and I sent it in to my buddies at the CIA and it made it to the Assistant Secretary for Preparedness and Response. So, the government had those documents when Rick Bright made those determinations. The assertion that there was no data on the effectiveness of hydroxychloroquine is just false. It's there. What is the motivation? You're right. None of this makes sense.

Both ivermectin and hydroxy are on the WHO list of essential medicines. They have been administered for millions and millions of doses. They are among the safest medicines we know when administered within the acceptable pharmaceutical window. Ivermectin is even safer than hydroxy. So Merck coming out of the blue and saying ivermectin isn't safe is really inexplicable.

I sit on the Active Committee for drugs as an observer. The Active Committee is the NIH committee that's guiding the clinical trials for these various repurposed and novel drugs. I saw, listened to, heard, and witnessed the representative of Merck that's on the committee, because the committee is full of pharmaceutical representatives even though it's an NIH public committee, explicitly attack the decision for the federal government to test ivermectin. She said there's no reason to do this. Since then, Active Sticks(?) is still testing ivermectin and they've had to go to a higher dose because as we pointed out, essentially the trials were designed to fail.

There is clearly a concerted effort on the part of multiple players in the pharmaceutical industry in concordance with the federal government to kill ivermectin as a potential alternative early treatment strategy.

Joe: And if you were going to follow the money, the problem is there's no a lot in ivermectin because it is a generic drug and any compound pharmacy can make it. And it's fairly cheap.

It's fairly cheap because it's easy to make. You can buy ivermectin in bulk for less than a penny a dose.

- The Chinese government has been using hydroxychloroquine, with effective results. Though, they have not been using ivermectin.
- The virus was ripping through Uttar Pradesh, India. Uttar Pradesh has 2/3 the population as the entire United States but is only 2% of its square mileage. The decision was made out of desperation to deploy early treatments as packages widely throughout the province. The package contained a number of agents, the composition of which has not been formally disclosed. It was done in coordination with the WOH, and whatever was in those package was rumored to include ivermectin, but there was a specific visit of Biden to Narendra Modi (Prime Minister of India). There was an explicit decision in the Indian government not to disclose the contents of those packages. Uttar Pradesh has flatlined in terms of deaths, while the US is still somehow struggling with Covid.

Joe: Isn't there some evidence that the vaccine actually helps people with Long Covid?

That was the rumor at the time. No there is no evidence. Anecdotally there was, but since then what we do know, for sure and well documented, if you've got prior Covid and natural immunity, you have a higher risk of adverse events from the jab.

- People who have natural immunity have a much higher risk factor for the whole spectrum of adverse effects, between 2 or 4-fold, if they get the jab.

Joe: But even though that's known, there are so many people out there telling people who have just recovered from Covid to get vaccinated.

It's nucking futs. It's just wrong.

- According to the study in Israel with 2.5 million people, [natural immunity] is about 27-fold better at protecting against developing the disease (note: infection does not equal disease).
- That is only 1 in over 140 studies that document that natural immunity is superior to the vaccine induced immunity

and by the way, as a vaccinologist and an immunologist, I wouldn't expect anything different.

- The CDC disputes this despite the evidence using a very small study with intrinsic bias, much smaller than the Israeli study, much less rigorous statistical power. The CDC study did this themselves.

Joe: So they funded this study, they did it themselves, and do you believe they did it with the intent of coming to the conclusion-

You're asking me to apply intent, and I've had too much time with lawyers and I'm not going to do it [chuckles]

What we're experiencing is a coordinated media warfare the level of which we have never seen before. And I and my peers who are experienced in multiple outbreaks have never seen this level of coordinated propaganda.

- The TNI (Trusted News Initiative), which began fall of 2020, ties together big tech and big media in service of the government and was built expressly for the purpose of "protecting our democracy and voting integrity from undue influence from hostile offshore players through media information campaigns." The TNI is the response of the Western nations to the alleged Russian interference. It surveys all information about elections to (allegedly) prevent intrusion of foreign information into the democratic process. Shortly after the TNI's creation, there was an awareness in the pharmaceutical industry that this organization could be used to address a particular challenge that they had: anti-vaxxers "(the label that is used to take anybody out that raises concerns about vaccine safety. Anti-vaxxer is the pejorative that is applied making it really easy

to basically take off the table anybody that is saying something contrary to the interests of the vaccine industry)." The TNI has also been deployed against climate skeptics.

So there was a decision that this same toolkit [TNI], this same integrated, international media and high tech organization, led by the BBC, would be pivoted to resisting "vaccine misinformation and disinformation". They let out a proud press announcement last fall that this is what they were going to do. They defined these things "misinformation and disinformation" as anything which was going to lead to vaccine hesitancy and which was contrary to the official statements of the WHO, or the respective national health organizations. [...] Whatever the CDC or Tony Fauci says is truth, by definition. Any information or discussion which is contrary to that truth will be suppressed, it will be deleted, and those people that are expressing these opinions that would lead to "vaccine hesitancy," which to some eyes would be informed consent, that information will not be allowed. And those people that are spreading that information will not be allowed to interact in the public sphere in social media. If you want to unpack this whole thing, it starts with understanding the Trusted News Initiative.

- The authors of the Great Barrington Declaration, esteemed and full professors, were systematically deplatformed by the federal government for criticizing the effectiveness of vaccine lockdowns, and labled as "fringe" epidemiologists.
- Sweden used a hands off approach and handled Covid much more effectively than the US
- Israel has a financial deal with Pfizer and only use Pfizer vaccines. Israel is on their 4th dose. Israel, compared to its surrounding states who don't have that level of vaccine uptake at all, has a significantly higher mortality rate.

Rate of infection is a hard variable because it is a function of the density of testing. The more you look for it, the more you find. The incidents of infection is completely contaminated by the frequency of testing and the density of testing. The only thing close to a decent outcome indicator that isn't subject to all this bias in the system, except in a few states: Iceland and Scandinavian states generally have relatively clean data, the UK to some extent has cleaner data, it is now clear that the Israeli dataset is contaminated by all kinds of monkey business in terms of what gets deleted... But, the only thing that seems close to a reasonable outcome variable is all-cause mortality.

- There are many variables that make it difficult to clearly define a vaccine-caused death, let alone a vaccine-correlated death.

[Malone lists many examples of how difficult it is to define, such as co-morbidities and physical trauma.]

All of these things you can't sort out what's what, you just have to take the aggregate value and hope that you have a large enough sample size that it corrects for all the [uncontrollable variable] noise that's inherent in the system.

Joe: Now you just glossed over the financial incentive to report a Covid death. What is that? What is the financial incentive? Because there are all these rumors that you would hear about what a hospital gets paid per Covid death and that the government gives them money, and that they're incentivized to make something- mark it down-

They're not rumors. I don't have the specific numbers off the top of my head. I'm not a hospitalist or a hospital administrator. But, the numbers are quite large. They're something like a $3,000 death benefit to a hospital if it can be claimed to be Covid. There's a financial incentive to call somebody Covid positive. The CDC made the determination in year one. This is why all our baseline data is junk.

The hospitals receive a bonus from the government, I think it's like 3,000 bucks, if someone is hospitalized and able to be declared Covid positive. They also receive a bonus, I think the total is something like $30,000

of incentive, if somebody gets put on the vent. Then they get a bonus is someone is declared death with Covid.

The CDC made the determination that they were going to make a core assumption: if PCR positive and you die, that is "Death due to Covid". An extreme example just to show the absurdity: If a patient comes in with a bullet hole to the head, and they do a nose swap and come up PCR positive, they are determined to have died from Covid.

Joe: (in disbelief) But is that real?

Yes

For sure trauma and other things.

Joe: I've seen that said, but I've always thought that's ridiculous.

It's not a question of what the hospital would do, it's a question of med codes.

Joe: So it really is true, that if someone has a gunshot wound, and they're dying of that gunshot wound, and if you check them for Covid, and if they're Covid positive, and they die, then they're marked off as a Covid death.

That is by definition from the CDC. It was a decision that was made early on.

The data has been so thoroughly manipulated that it's hard for any of us to make sense of it.

[Explanation of how laws and treaties work for clinical trials.]

Over the last few years, the FDA made policy that the responsibility vests with the sponsor. That's fancy regulatory talk that Pfizer owns it. So you ask the question: Whose responsibility is it to ensure that the data isn't contaminated and manipulated? The answer is Pfizer.

What gets reported in a study is often biased by how the study is structured. Because when you write the study protocol, you list the expected adverse effects. So if those things happen, often times those things get checked. But I guarantee one expected adverse events was not seizure and paralysis.

There's all kinds of financial incentives to make bad stuff go away and highlight good stuff. It makes the sponsor happy. And then you get another contract. These are not little contracts. A modest contract is 20 million dollars. A big one is 100 million or more. These are big money deals. You want to keep that money flowing, and you want to keep your sponsor happy. So that's what has come out with the whistleblower from Pfizer is that the contractor, I think it's here in Texas, that ran a bunch of those clinical trials and appears to have manipulated data in a variety of ways. And this is done at the level of checking the data and reconciling the data and deciding which things go into the database and which things don't go into the database. And whether or not if someone had an adverse event after shot 1 and then they're dropped because they won't take shot 2. Do we drop them out of the overall study analysis? We have all this specific language that we use in our business: the "intent to treat cohort," the "per protocol cohort," these are separate analyses because its known that you can manipulate the data in these different ways.

- Thomson Reuters Organization has become the "fact-checker" of choice and is tied closely to Pfizer with common corporate ownership. They are the fact-checker of Twitter. Integrated on a board level. Thomson Reuters is making the decisions, which has connections to Pfizer, about what information is allowed to be discussed on Twitter.

(Speculation) If I was to follow the money [...] Hospitals are incentivized to treat Covid patients. If Covid patients are treated outside of the hospital and are therefore prevented from going to the hospital, such is the case in the imperial valley where Bryan Tyson and George Fareed have saved thousands and thousands of

lives of indigenous Latinos [...], and if people are giving treatments that are keeping people out of the hospitals, then they're not getting that revenue.

- The people who are doing the attacking are almost universally hospital administrators and hospital-based physicians.
- There is a recent paper out of Hong Kong: Comprehensive Analysis Myocarditis in Boys Hospitalized.

The myocarditis was so bad after vaccination, and these are all verified post-vaccination. It was so bad that you went to the hospital. Incident rate is 1 in 2700. There's all kinds of handwaving that "oh myocarditis is mild and the recover from it". Those statements aren't, let's say, gently based in fact. Historic incidents of death post-myocarditis is about 27%. The assertion is "well this is a different kind of myocarditis and therefore it's not going to kill these kids or young adults." These things are being said in the absence of data. It's pure speculation.

Joe: I keep hearing that it's "mild myocarditis" and that it "eventually goes away," but not citing any studies, and I don't think there are any long term studies.

There can't be! [chuckles] By definition!

I think I might be the only one that's deeply involved in the development of this tech that doesn't have a financial stake in it. So for me, the reason is, because what's happening is not right. It's destroying my profession. It's destroying the practice of medicine worldwide. It's destroying public health in medicine. I'm a vaccinologist. I've spent 30 years developing vaccine - a stupid amount of education learning how to do it and what the rules are. And for me, I'm personally offended by watching my discipline get destroyed for no good reason at all, except for apparently financial incentives and, I don't know, political ass-covering?

There is a huge number of dysmenorrhea and menometrorrhagia, alterations in [menstrual cycles] in women.

Then there are the women who are postmenopausal that have started bleeding.

Why is this happening, what are the things that connect these things? What is it that drives menstruation. The answer is the ovary. The ovary is the controller through hormones and ovulation. What did we learn early on from the Pfizer data package? Which by the way, when that was disclosed by [name?] from Japan and sent to me, was the first thing that really lit me up and let me know that something here was rotten. When I got that, I picked out, as [name?] had done, I was given the task of independently evaluating it, and then I took that package and I gave it to a more senior regulatory professional that I respected and I said "these are the things I see. This looks really bad." He said "Oh you missed this that and the other thing." These missing things include reproductive toxicology, evaluations of teratogenicity (birth defects), standard stuff that's always done. Genotoxicity, not done. What was done was a cobbled together group of data that didn't even involve the vaccine. It used other mRNAs in non-GLP, that's fancy speak for "not done with rigor" or "not according to the rules" - all cobbled together and sent in to the regulatory agencies of the world to justify going and head and giving jabs to everybody under emergency use authorization. That's the truth of it. That's the short version using common language.

- An early test they did do was on rats showed that the mRNA goes to the ovary at a very high rate. This wasn't supposed to happen. It was supposed to stay in the arm at the injection site. It instead goes all over the body, and specifically to two places that are kind of anomalous: bone marrow and the ovaries. We can isolate it to the ovarian signal because it doesn't occur in testes. So we have a non-clinical trial (rat trial) that shows affects on the ovaries. And when it is deployed widely in humans, we continue to see the alteration in menstrual cycle.
- Rabbis of the Hasidic Jews had to closely monitor the effects on their women's menstrual cycles because of their religious concern with cleanliness (see the Pentateuch on menstrual cleanliness). There are strict

rules on cleanliness during intercourse. These Rabbis, being very familiar with their women's menstrual cycles, immediately recognized disruptions in the menstrual cycles of their communities. They came out with a clear statement that children should not be vaccinated, authenticated by law. And with adults it was strongly discouraged.

Your girls are born with all the eggs they'll ever have. And these lipids appear to be affecting menstruation in some way. But menstruation is just one of these adverse effects.

- The disease itself (Covid), the mRNA genetic vaccines, and the DNA virus administered genetic vaccines (J&J) all have these symptoms: clotting, brain fog, etc...

We don't see these problems by the way - adenovirus vector vaccine have been in development for my entire life, 30 years. There are licensed adenovirus vector vaccines. So it's not something that's intrinsic to the platform. Well what is it? The common variable is spike. Just to cut to the chase.

Joe: Spike proteins?

Yes.

[A lot of technical jargon in this segment somewhere around 1:30:00 that I'm honestly too tired to transcribe. He describes the effects lipids and proteins and spike etc...]

It is the job of the pharmaceutical companies to prove that their genetically engineered spike is safe. They never did that. And so all of this pressure that comes back from folks like me [...] I get criticized because "oh well prove that it's not safe." I'm sorry, that's not the way it works. It's pharma's job to prove that it is safe. It's not my job to prove that it's not safe.

Does it cause toxicity in people? I think the answer is pretty clear now: it does. The question we're asking now is: how often and how bad?

- There is a paper out that tried to explain the difference between Long Covid and post-vaccination syndrome. It concluded that the two are indistinguishable.

There's this increasing awareness that there is some window of time after vaccination, not sure how long, when you're actually more susceptible to infection. So not only is the vaccine efficacy weaning, but the multiple jab strategy is actually creating more and more windows where people have this period of T-cell suppression.

Joe: This T-cell suppression, are there any studies on the amount of time that it takes before your system rebalances itself post-jab?

This is the obscenity for me of this whole, "we're going to give four shots because we don't really know what to do and we need to do something." I like to talk about the metaphor as a father: If you get a three year old a hammer, everything becomes a nail. That's kind of a simple way of saying people that aren't well trained given a powerful technology or tool will abuse it and overuse it. In this case there are multiple reasons not to do the multiple jabs. The simplest one for everybody to understand is, when your son develops seasonal allergies to pollen or whatever and its so bad that he can't go to school you say "oh well lets take him to an allergist". What do they do? They give him shots. What are those shots? They're high doses of antigen that are administered repeatedly to your child. It induces something that as immunologists we call high zone tolerance. High zone tolerance basically amounts to an ability by giving multiple injections at high levels of antigen t o shut down T-cells in an antigen specific fashion.

- Malone clarifies that the T-cell suppression is only against that antigen, and likely does not affect anything else about the immune system but does not claim that there is absolutely 0 broader effect.

The other things is that these are multiple jabs that are mismatched for the current circulating virus. That's akin to repeatedly taking a flu vaccine from two seasons ago and hoping that it's going to protect against this flu.

- Malone was infected twice 4 months after taking 2 jabs of moderna, infected with both the original Wuhan strain and Delta

The window of efficacy seems to keep shrinking (effectiveness of the vaccine)

There is signs in some data, from Denmark, of negative efficacy against Omicron as a function of the number of vaccinations up to 3. Positive efficacy meaning it protects you. Negative efficacy meaning your probability is higher if you've taken the vaccine. It's compared to unvaccinated. It seems to be somewhat higher if you've had 1 jab, even worse if you've had 2, even more likely to get infected if you've had 3 injections.

- Malone describes an anecdote to show how someone who is vaccinated is more likely to participate in dangerous behavior, behaviors with increased likelihood of infection like clubbing and going out, because they feel protected by the vaccine. He says this to say that it may not be the vaccine itself causing the increase in infection, but the resulting behaviors, which are variables unaccounted for. The FDA did not force any pharmaceutical company to collect this data even though they should have.
- Malone goes on to say there are studies out and coming out now about the correlation between jabs and increase in infectivity. The data came from the Netherlands, likely their government. The statisticians are debating how to interpret the data because of how contaminated the original data is, regarding the numerator (total infections).

Joe: So would the assumption be that there's something that's happening to people that are vaccinated where it makes them more susceptible to this particular strain of Covid is a vaccine escape variant?

So now what you're doing is trying to impose a hypothesis. Which is good! And one of many possible hypotheses. So in a world, a proper world where we are allowed to debate these things, and do these kinds of studies, and examine these kinds of variables without being [draws finger across his neck] in social media, we'd have a very active discussion about this hypothesis and many others. That's my way of not answering your question.

What we're doing with administering mismatched vaccine, we're driving the effector in memory cells, B and T, towards a population that is focused on a virus that no longer exists. In immune response you don't get everything.

You didn't ask the question but I'm gonna answer it anyhow: What are your hypotheses for the poor durability of the vaccines? My answer is: it looks to me like original antigenic sin. Well that's kind of a cool terminology. What that means, let's unpack original antigenic sin, and what I think could be happening with these data, following your hypotheses you just shared, consistent with that, is that we're driving the immune response towards an antigen, the receptor binding domain of spike, that no longer exists with Omicron. It was initially denied, but it has become clear that all of us have a background immune response against beta coronaviruses. These are naturally circulating cold coronaviruses that have significant immunologic cross-reactivity with SARS COVI-2. And the problem with that, and original antigenic sin, is that those existing memory cells will dominate the immune response when you get infected and when you get vaccinated.

Now let me unpack that in a way that makes sense for the common person. [...] The sum of your life experiences biases how you respond to - take you for example, in your martial arts, you must know this. What you've experienced in the past in prior fights is gonna bias how you respond to a new opponent. Same happens with your immune system. [...] The prior exposure of your immune system to an antigen that is closely related to a new antigen [biases your immune system as if it were the responding to the old one].

It could very well be, that the further you're taking jabs, the further you're skewing your immune response in a way that's dysfunctional for infection to Omicron compared to someone who is immunologically naïve.

- Prior strains of Covid infected the deep lung. As the new strains are developing, it appears they are settling more in the throat instead. While it has a higher rate of infectivity, it is less pathogenic.
- The CDC modelling data suggested that by now all covid cases would be around 70-80% Omircon, which is now understood to be erroneous modelling.
- WHO asserts that there are no deaths associated with Omicron in the world at this moment. The mortality of Omicron is remarkably low. The official symptoms list for Omicron is pretty much identical to the common cold. It is a mild variant and is able to escape prior vaccination, typically because of a mismatched vaccine.
- The reproductive coefficient of the original Wuhan strain was about 2 to 3. Meaning on average, one would infect 2 to 3 other people if they have the virus themselves. Delta had a coefficient of 5 to 6. Omircon is about 7-10. That's measles territory.

What that means is, we're all going to get infected, regardless of mask usage or social distancing.

Our government is out of control on this. They are lawless. They completely disregard bioethics. They completely disregard the federal common rule. They've broken all the rules that I know of that I've been trained on for years and years and years. These mandates of an experimental vaccine are explicitly illegal. They are completely inconsistent with the Nuremberg Code. They are completely inconsistent with the Belmont Report. They are flat out illegal and they don't care. And the only thing standing in between us, and it's too late for many of our colleagues, including my unfortunate colleagues in the DOD (federal employee mandates). Hopefully we're going to be able to stop them before they take our kids.

- Most of the press statements on Omicron infectivity is based on modeled data, not real data, but it is shown as if it were real.
- The hospitalizations due to Covid appear to be dominantly Delta, not Omicron.